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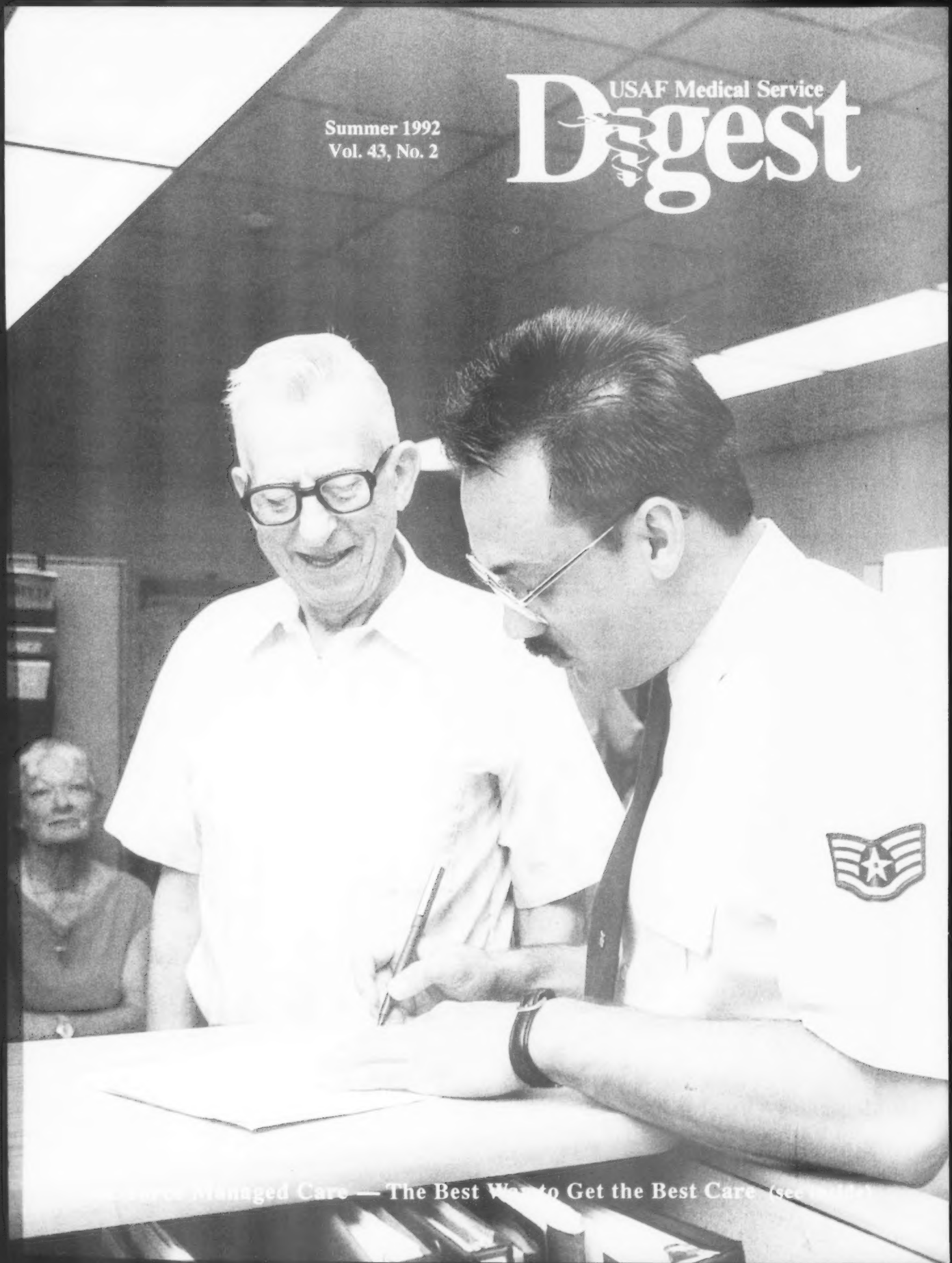
USAF Medical Service Digest



Managed Care — The Best Way to Get the Best Care (See [illegible])

USAF Medical Service
Digest

Summer 1992
Vol. 43, No. 2

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From the Editor

The Board and I would like to know what you think of the *Digest*. Do you find it useful, informative, interesting? We value your opinion, and we welcome your comments and suggestions. Please write to:

HQ USAF/SGI
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Attn: *Digest* Editor

Elizabeth G. Taber

ELIZABETH G. TABER
Editor, *USAF Medical Service Digest*
Office of the Surgeon General

Front cover: Participating in the Air Force Catchment Area Management Demonstration at Luke AFB, Ariz., SSgt. Jeffrey Irwin refers an eligible patient to a participating civilian health care provider.

Message from the Surgeon General

Working Toward A Better Medical Service, Happier Patients

Welcome to tomorrow's Air Force! A stronger, more responsive Air Force Medical Service is evolving at an incredible pace. By restructuring and streamlining our operations, we are moving toward a better, more efficient way of supporting the Air Force mission. Positive changes are underway with the reorganization of the surgeon general's office at Bolling AFB, Washington, D.C., the Air Force Medical Support Agency at Brooks AFB, Texas, and the School of Aerospace Medicine, also at Brooks. I encourage you to read about all of these in the following pages of the *Digest*.

We are also implementing the Coordinated Care Program Air-Force-wide over the next few years, one of the greatest peacetime challenges — and opportunities — we have ever known. No longer will we focus only on the delivery of health care within the confines of the medical treatment facility. We will design, implement and manage health care delivery programs for our beneficiaries. They, in turn, will rely on our abilities to provide and obtain the best possible care for them. As we adapt to this new environment, we must remember the fundamental goal of these changes — the well-being of our patients.

Our patients have always been our number-one priority. Everything we do is an attempt to serve them better. We continue to see a high degree of patient satisfaction with our services. In fact, the Air Force Health Care Survey conducted between January and August 1991 revealed that patient satisfaction has increased since the last survey in 1989. A clear majority of the respondents, from 70 to 85 percent, were satisfied or very satisfied with their care across all specialty areas. Surgery and family practice were among those specialties with the highest satisfaction, and our most satisfied patients were retirees.

Although these results are encouraging, there is room for improvement. We want our patients to be more than satisfied with their care — we want them to be delighted! Achieving that goal in these days of draw-downs and base closures will be a challenge, but it is one that I know we are up to. I have absolute confidence in our ability not only to survive but to prosper in the days ahead.

I am proud of your efforts. The approval expressed by our patients for the care you give them tells the world that we have the best medical system in existence. You are a first-rate medical team that the Air Force family can depend on, and this is one thing that I know will not change.

Alexander M. Sloan
Lieutenant General, USAF, MC
Surgeon General

USAF School of Aerospace Medicine: The Old and the New

Col. Kenneth R. Hart, MC
Col. Bryant D. Mauk, MC

The USAF School of Aerospace Medicine, located at Brooks AFB, Texas, trains Medical Service members to support the U.S. Air Force aeromedical mission. This support includes medical care and the full range of environmental, occupational and preventive services that enable people to work in complex and adverse environments. Providing this unique education, the school's faculty includes the staff from the Human Systems Division (HSD), the Air Force's center of research and clinical and preventive medicine, dedicated to investigating human factors in Air Force systems and operations.

The history of the School of Aerospace Medicine parallels the development of aerospace medicine as a specialty. In 1917, Lt. Col. Theodore Charles Lyster, the first chief surgeon of the Army's aviation section, directed the establishment of a medical research board, and aviation medicine was born. Lyster, known as the Father of American Aviation Medicine, was concerned that officers of the time did not understand the unique medical problems of aviation. He also saw the need to immediately train physicians in aviation medicine, calling them flight surgeons.

A young flier takes an altitude test at the School of Aviation Medicine, Randolph AFB, Texas. The school was located at Randolph Field from 1931 to 1959.

To accomplish both of these purposes, the Medical Research Laboratory was opened in 1918 at Hazelhurst Field, Mineola, Long Island, N.Y. Its major emphasis was on research, studying the physiological effects of flight. Gradually, however, the emphasis and mission of the laboratory changed from research to education as it became a major training school for flight surgeons. The shift also resulted from a government decision in 1920 to discontinue funding and support for continued aviation research. In 1922, the lab's name changed to the School of Aviation Medicine, and it moved to Brooks AFB in 1926.

Although many of the faculty and students were involved in informal studies, an aeromedical research program was not justified again until the 1930s when emerging leaders reestablished the need for a broadened aeromedical mission. The school moved to Randolph Field, Texas, in 1931 during this time of renewed interest. However, the aeromedical mission continued to wax and wane through World War II.

In the 1950s and 1960s, after the establishment of a separate Air Force and Air Force Medical Service, focus returned to the uniqueness of flight medicine. The School of Aviation Medicine returned to Brooks AFB in 1959, as part of a new Aerospace Medical Center, and became the School of Aerospace Medicine in 1961. The new Aerospace Medical Center combined aerospace medical research, education and clinical treatment.

During this time of growth, the American Board of Preventive Medicine certified aerospace medicine as a specialty, accrediting the school's aerospace medicine residency. The School of Aerospace Medicine soon became — and continues to be — the sole Air Force training institution for the aerospace medicine program, which includes flight medicine, aerospace physiology, military public health (environmental health), bioenvironmental engineering and aerospace nursing. The School of Aerospace Medicine, now recognized internationally for its outstanding education, actively partici-

Today, in hypobaric chamber training at the USAF School of Aerospace Medicine, Brooks AFB, Texas, a group of flight nurses experiences altitude simulations without leaving the ground.

pates in training and educational interchanges with many foreign nations.

Changes in the School

Just as it faced challenges and change in its beginnings, the School of Aerospace Medicine experiences change today, adapting to the evolving needs of the Air Force and the Air Force Medical Service. The school's own recent restructuring is in response to vast reorganization, force reduction and streamlining in the Air Force and ensuing changes in health care demand and Medical Service requirements. As in the past, the school accepts new challenges with a positive outlook, using the challenges as opportunities to expand the aerospace medicine program and to enhance the quality of academics.

As a result of one change, the consolidation of HSD laboratories, research elements of the School of Aerospace Medicine have been realigned within the Armstrong Laboratory, creating the largest human-oriented aerospace research laboratory in the history of the aerospace medical program. Associated with this change was the consolidation of all academics of the school and a reorganization of the overall educational program, sharpening the focus of the school academically and integrating those resources of the laboratories essential to the educational program.

As a result of the reorganization, a complete review of the school's 48-course curriculum has already begun. So far, the review has resulted in the addition of one year to the aerospace medicine residency and the expansion of several other programs involving human factors, mishap investigation, environmental protection and the aerospace physiology education program.

Another major organizational change taking place at the school is a switch to university-type organization, which requires a more formal faculty structure. To create this structure, a faculty board was established as a governing body, made up of school staff members and representatives from HSD. The board has since established criteria for faculty selection and has been successful in assigning appropriate faculty members to teaching assignments throughout various departments.

Under the new organization, faculty members will not only teach, they will also be involved with students as preceptors and will participate in curriculum development and course management. This approach is expected to enhance the quality of the courses and to increase the number of faculty members, offering a broader spectrum of expertise and the ability to expand curricula when needed.

To help the Armstrong Laboratory and the School of Aerospace Medicine integrate their educational programs, and in keeping with the organizational structure of other military academic institutions, the HSD commander has been named commandant of the school. The school's commander has been given the additional title

Perimetric field studies were conducted at the School of Aerospace Medicine, Randolph Field, Texas (1931 - 1959).

Above: A student, Sgt. Phil Haenen (left) receives a demonstration in sensory illusions via the Barany chair and instructor TSgt. Mike McCormack (right). Right: An equilibrium test using the balancing chair of yesterday.

of dean, and an educational advisory board has been formed. The board, made up of nationally recognized leaders in medical education, aerospace medicine and preventive medicine, will serve as an advisory group to the commandant and dean of the school.

To further improve the education offered at the school, university affiliation is being developed with the University of Texas School of Public Health at Houston and the University of Texas Health Sciences Center in San Antonio. Other affiliation agreements are also being finalized with public health agencies in the San Antonio area. The School of Aerospace Medicine is accredited by the Accreditation Council for Graduate Medical Education to provide an aerospace medicine residency program. It is also accredited by the Southern Association of Colleges and Schools through the Community College of the Air Force.

Conclusion

As the Air Force consolidates and refines its organizational structure to meet the new military requirements of a nation in a changing world, the School of Aerospace Medicine and associated Armstrong Laboratories will continue to respond to the changing needs of the Air Force. The school remains dedicated to the development of the people and knowledge needed to meet the vital health and environmental demands of Air Force operations around the globe.

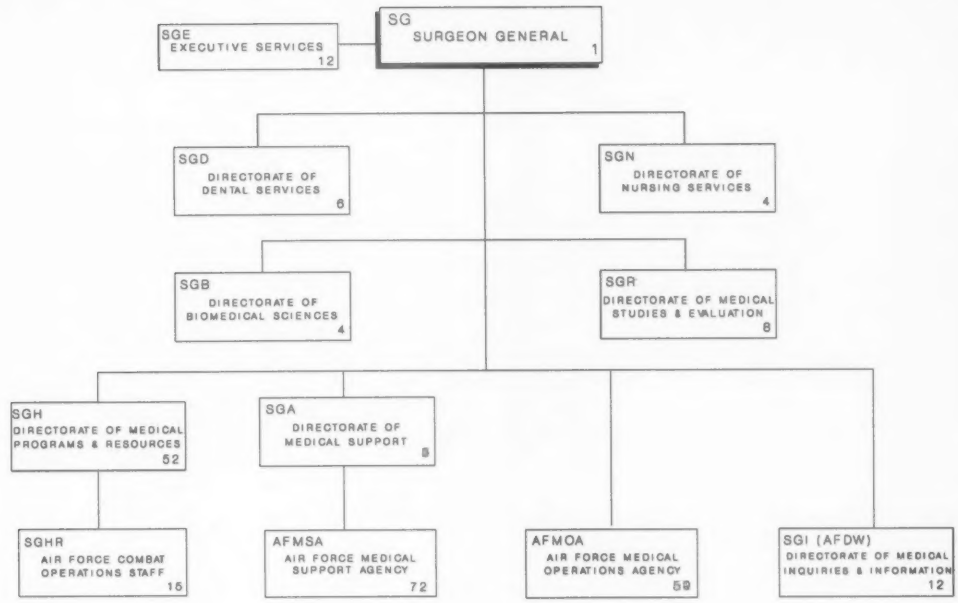
Col. Kenneth R. Hart is the commander of the USAF School of Aerospace Medicine, Brooks AFB, Texas, and Col. Bryant D. Mauk is the school's vice commander.

A New Look for the Surgeon General's Office

Maj. Michael L. Hopper

This summer, the Office of the Air Force Surgeon General (AF/SG) will take on a new look. Secretary of the Air Force Donald B. Rice recently approved the AF/SG proposal for reorganization of its headquarters staff. This reorganization was the AF/SG part of an overall effort, initiated by Air Force chief of staff Gen. Merrill A. McPeak, to reduce the size and scope of the Air Staff to better meet the needs of a future downsized Air Force. Lt. Gen. Alexander M. Sloan, the Air Force surgeon general, calls the new organizational proposal "a straightforward structure that will serve us well as we move into the future."

Since the purpose of the Air Staff restructuring was to review the roles and functions of Air Force headquarters relative to the Air Force of the future, a Reorganization Process Action Team was developed and challenged



to perform this task for AF/SG. The team, made up of senior SG staff, looked hard at the Air Force Medical Service and the changes expected in the next six years. After a series of reviews and modifications, the final reorganization proposal emerged (above). The new organizational structure is more streamlined and incorporates a 22 percent reduction of manpower. Following is a brief description of what has changed.

One change involves the redesignation of the Air Force Office of Medical Support Field Operating Agency (FOA) as the Air Force Medical Support Agency, and another includes the establishment of a new FOA, the Air Force Medical Operations Agency. The new FOA will be responsible for clinical and quality practices, aerospace medical procedures, clinical investigations management, health promotion, family advocacy program issues and the DOD Radioisotope Committee Secretariat. These functions were previously performed by the Directorate of Professional Affairs and Quality Assurance (HQ USAF/SGP) and its subordinate divisions. The reorganization moves these functions out from under the Air Force Office of Medical Support FOA and recognizes them with a stand-alone mission.

Another change establishes a new division to spearhead Air Force implementation of managed care. Previously, no single Air Staff office was responsible for all of the issues surrounding the managed care program. The Reorganization Process Action Team recognized managed care as one of the greatest challenges facing the Medical Service in the coming years and established a division in the Directorate of Medical Plans and Resources (HQ USAF/SGH), institutionalizing the Air Force's commitment to this important program.

Many office and position titles have been changed throughout AF/SG to better reflect functions and roles. The most dramatic of these changes was the deliberate shift from the title "corps chief" to the more recognized staff title of "director." Although each Corps still has one senior member who performs corps chief functions, the primary role of these highly valued senior Air Staff members is to assist the surgeon general in defining broad policy and plans for all members of the Air Force Medical Service.

These AF/SG organizational changes, although they should have little impact at the base level, demonstrate that from the top down, the Air Force Medical Service is committed to doing whatever is necessary to continue providing the best services for the best Air Force.

Note: Reorganization will be completed this summer. During the transition period, new functional address symbols and duty titles can be used informally, but until Air-Force-wide data systems are updated, old office symbols will stay in use. Official notification of organizational changes will be released through normal Air Force channels.

Maj. Michael L. Hopper is a health manpower resources staff officer for the medical manpower division of the medical plans and resources directorate in the Office of the Air Force Surgeon General.

The *Digest* Interviews

Brig. Gen. Peter C. Bellisario

On April 14, 1992, the *Digest* interviewed Brig. Gen. Peter C. Bellisario who became the director of Medical Support last August. In the interview, Bellisario discusses upcoming changes and pertinent issues facing the Medical Service Corps as an integral part of the Air Force Medical Service.

Digest: What do you feel is today's greatest challenge for the Air Force Medical Service Corps?

General Bellisario: When I look at the greatest challenge for the Medical Service Corps, I see it as an integrated facet of the challenge facing the overall Air Force Medical Service. Today, the challenge is restructuring our hospitals to meet the expectations of our commanders, administrators and ultimately our patients. We need to ensure that the policies we provide will give our people the greatest flexibility to execute their mission.

The surgeon general wants to empower the command surgeons to execute the mission of their major air commands. Command surgeons will be empowered to give local commanders complete authority, responsibility and resources for their missions and hold them accountable. Although these principles have been talked about in the past, now we are watching them become reality. Our model will be the Tactical Air Command (TAC) Catchment Area Management demonstrations at Luke AFB, Ariz., and Bergstrom AFB, Texas. They will be the prototypes that the rest of us are going to learn from and be able to proliferate.

This is the toughest thing to do, our greatest challenge, because we are used to the way we have always done business. We are at a time right now when the greatest amount of change is going to happen in a hurry, and local commanders of our institutions should be given everything that they need.

Digest: What are some key issues that you plan to focus on as the director of Medical Services?

General Bellisario: A key issue will be ensuring that the functional areas I am responsible for are going to be able to adjust to the new way of doing business. The business case approach, which has been integrated through the Corporate Information Management (CIM) process, will play a large part in our executing the changes and will help us provide improved logistical support. Identifying the information flow that ties medical logistics to accounting and finance and contracting is a pretty important part of taking the first step. The goal is to streamline the process and offer a better service to all medical logistics customers.

Automation is a pretty important part of smoothing out that process. I know that the Composite Health Care System has gotten some good and bad reviews, but it is a first step. We have never had an integrated system that puts all the information about each patient on one central system. Now we will, and we can start developing a more functionally focused information system from the grass roots up. This is a big challenge with integrated automation: getting the functional people involved in how the system is going to work rather than the systems people.

Coordinated care is another key issue. Managed care is a local issue, and it will be implemented and structured based on how the local base does its job. Each base has different needs and ways of executing the mission. That is why it is important that the commanders be given the flexibility of how they are going to make managed care work.

Digest: What are your thoughts on Total Quality Management (TQM)? Where is the Medical Service Corps going with it and how?

General Bellisario: I always felt that my bosses empowered us to do our jobs. As an administrator, I worked closely with the director of hospital services and the director of nursing services. When we were working issues, we felt that the three of us could sit down without the commander there giving us directions all of the time and that together we could figure out a better way to do business. I see TQM as implementing that philosophy across-the-board. To empower means to trust.

While implementing TQM, I hope we do not get bogged down in the process by looking for more numbers before decisions are made. Once the process slows down to wait for another two weeks' worth of information or another month's worth of data to make a better decision, it slows the whole system down. Also, as we develop process action teams, or process improvement teams, we need to allow the people who are working at the clinic level and are closer to the action to make adjustments. We need to let them express their ideas for improving patient flow through our health care system. TQM allows people to use their creativity to influence change and remove unnecessary barriers.

Digest: What is the status of recruiting and retention in the Medical Service Corps?

General Bellisario: The Recruiting Service has improved their screening of prospective applicants before the applicants are reviewed by an accession board. The quality of the applicants is much higher, and their records are very competitive. When we selected 48 MSCs at the last accession board, we accepted one in three, which is a change from the past when we accessed one in 10. The people we are taking right now have great academic records and civilian hospital experience, and most of them have master's degrees in health care administration or business administration. They are eager to get involved in the way we are doing business. It is up to those in leadership positions to allow these individuals to make an impact.

Retention concerns me because of all the changes that are underway in the U.S. Air Force. We have a lot of talented people in the Air Force Medical Service, and they need to understand that they make a difference in what we do. They need to know that their skills are necessary and that we will have a place for them to work and make an impact. We have the right people and a great mission with a future in the DOD health care delivery system.

Digest: What are some new opportunities facing MSCs?

General Bellisario: The new opportunities for MSCs are the same as those facing the entire Medical Service. New situations will arise, and we must ensure that our people are trained to respond to them by taking

advantage of new technology, using it in a smart fashion and sharing the knowledge with others. We all share in how resources are used, and we are getting into some new technologies that are really awesome. How we take advantage of them and integrate them is important. For example, we are investing in Medical Diagnostic Imaging Support (MDIS) systems at the USAF Medical Center Wright-Patterson, Wright-Patterson AFB, Ohio, with follow-on installation at Wilford Hall USAF Medical Center, Lackland AFB, Texas. We are also using teleradiology at small TAC facilities and at isolated overseas locations such as Kunsan and Lajes. This new technology provides digital images that can be electronically stored, retrieved and transmitted within the hospital as well as between hospitals. It will allow physicians to access radiological images from their offices and will reduce retakes and lost films. This "cutting edge" technology now applies to medical images, but it holds great potential for digitally capturing all forms of patient physiological data in the future, thus making a true patient record more feasible. We hope to demonstrate that this new technology is not only efficient and cost-effective, but that it is so user-friendly that the providers will absolutely love it.

It is interesting to note that technologies developed for weapons systems are now being applied to health care. A part of MDIS came from TRW. One of my goals is to help the practitioners, to enhance their capabilities. I want to make their lives the easiest in the world, and new technology is a way of accomplishing that.

Digest: What can we expect from Selective Early Retirement Boards (SERBs), the Voluntary Separation

Initiative (VSI) and the Special Separation Benefit (SSB)?

General Bellisario: The programmatic cuts that we are taking are based on base realignment and closures. Our personnel losses are much less dramatic than cuts in the other services. The Medical Service has not participated in SERBs; however, that may change. Colonel requirements for the Medical Service Corps, the Biomedical Science Corps and Nurse Corps are under review. For example, if we have 90 full colonel MSCs today, and our end requirement is, say 80, then there is going to be a SERB.

The Medical Service has elected to participate in the second phase of the VSI/SSB. Certain officers, deferred for promotion to major and lieutenant colonel, will be offered the opportunity to apply. If their applications are approved, these officers will separate no later than September 29, 1992. They need to look at the bullets that apply to each one of these choices before making their decision. It is important that we understand what is facing our people on the outside, what the market is like. They need an opportunity to refocus. This means that transition assistance programs should have some time to expand their number of course dates and course lengths to help our people walk through the right steps if they choose to get out. The bottom line is that these are all on the board, and we are authorized by law to continue with them through 1994.

We do not do all of this in a vacuum. People need to understand that when Congress discusses Guard and Reserve force reductions, they are discussing, basically, a zero sum game. If congressmen will be able to sustain the units in their districts, somebody else will pay for it. Everything is a tradeoff, but force restructuring, SERBs, VSI and SSB are here and must be dealt with.

Digest: How has the role of the Medical Service Corps changed over the past 10 or 20 years?

General Bellisario: The utilization of the corps, members and various functional groups has changed. When there were large numbers of bases, frequent moves were a part of everyone's life. Now our people are staying in jobs and at bases longer. They will spend more time really getting into the nuts and bolts of the issues. When they were at a base for only 12 or 18 months or two years, they really did not have a chance to learn all aspects of their job. They never really got into how their responsibilities affected the entire institution. Now Medical Service people will be at a base longer and will have the opportunity to learn more about their specialty. In the long run, this will bring a greater stability to the management style of the institution because they will not be turning over 33 percent of their staff every year. They will be able to work with problems over a longer period of time and, hopefully, solve them using the continuing process of TQM.

As roles change, we still need to understand that performance is the basis for success. No matter how we perceive our roles, we need to understand how they fit into the overall picture and do our jobs to the best of our ability. The process action team on policy is going to reduce to overall size of our directives. Reducing the AFR-168-4 by 30 percent and then by another 50 percent, is going to force a rethinking at the base level of how they are going to do their jobs without a lot of "how to" in the book. They are going to have to use their creative juices in a new way.

Digest: Do you have a personal message for the Medical Service Corps?

General Bellisario: My message has always been that we have the right people doing the right things at the

right time. We have always taken care of our people, and we will work extra hard to do this in these times of great change. As we face the future, we must not overlook our past. We have always prided ourselves in operating the best health care system around. We have made adjustments in a smart fashion, and we will always do this with the ultimate goal of providing the best possible care to our patients. Today's challenging environment is an exciting one, and it is great to be part of a team that is meeting the challenges.

Digest: Thank you, General Bellisario.

Featuring

Langley AFB

(Editor's note: Tactical Air Command is now part of Air Combat Command with headquarters at Langley AFB.)

Capt. Deborah A. Seaman, MSC

America began its struggle for existence on the Virginia Peninsula when the English established their first settlement in the vicinity of Hampton, a city resting on the southern tip of the peninsula. In December 1606, three small vessels carrying 100 men left England to establish a colony in Virginia. In April 1607, the colonists' ships entered the Hampton Roads Harbor and continued sailing up the James River, landing 35 miles later at a place they named Jamestown. That historic landing marked the origin of English-speaking America. Hampton itself is well-known as "a city of many American firsts," holding the distinction of housing America's first free education, the first continuous Anglican church and the first training site for America's astronauts. Hampton is also home to Langley AFB and America's "First Team."

The Beginnings

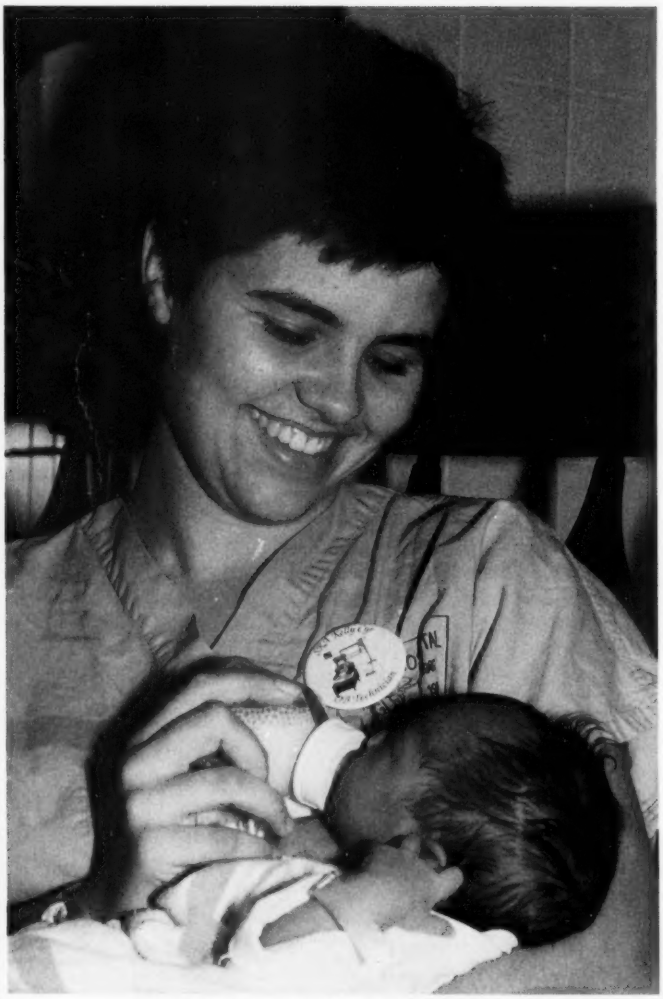
The need for establishing Langley AFB was recognized in 1916 at a meeting of the National Advisory Committee for Aeronautics (NACA). The committee agreed that a joint experimental air field and proving ground for aircraft should be developed for use by the Army, Navy and NACA. On June 28, 1917, the base was authorized as an experimental station and named Langley Field after Samuel Pierpont Langley, a pioneer aeronautical scientist and secretary of the Smithsonian Institution from 1887 to 1906. Construction began under the supervision of the Air Service Station of the Army Signal Corps.

The Tactical Air Command (TAC) was activated in March 1946 and moved its headquarters to Langley AFB to be near Continental Army Command headquarters at Fort Monroe and Atlantic Fleet headquarters in Norfolk. The NACA, established by Congress in 1915, has since become the National Aeronautical and Space Administration (NASA) and maintains its largest laboratory at Langley, the Langley Research Center. The center engages in the research and development of manned and unmanned space vehicles, satellites and rockets.

The Surroundings

More than 139,000 people now reside in the thriving metropolis of Hampton. Because of its terrific location on the water, Hampton enjoys abundant seafood and water recreation. The city is famous for its fish, crabs and oysters. Sunny days and mild temperatures make sailing, motor-boating, water-skiing, fishing and swimming pleasant pastimes during the long summer months. Nearby Gosnold's Hope Park offers additional outdoor recreational opportunities. The park has more than 90 acres of campsites and wooded areas and all types of

The Honor Guard adds color and ceremony to beautiful Langley AFB in Hampton, Va.



SrA. Kelly Cyr, obstetric technician for the 1st Medical Group, Langley AFB, Va., feeds a newborn in the Air Force's third busiest obstetric unit.

facilities, including an outdoor amphitheater. For anyone seeking to expand their horizons, the Hampton Coliseum, one of the most beautiful and functional cultural centers on the East Coast, accommodates all kinds of trade shows, conventions, exhibits, athletic events, musical productions, public and private meetings and many other community programs.

Hampton has a reputable school system. Its 35 public schools have a total enrollment of more than 25,000 students. The NASA Apprentice School also provides technical training in all branches of aeronautics. Extension courses are offered in cooperation with the University of Virginia, and other non-credit adult vocational courses are taught at night. Hampton is also home

A1C Davina Ogledzinski takes blood from a patient.

to Hampton University, a college of liberal and applied arts and sciences and teacher education.

The Base and the Medical Team

Just as Hampton has flourished over the years, Langley AFB has grown to be one of the most important bases in the world. The list of aircraft stationed at Langley AFB since 1917 sounds almost like a complete inventory of American aircraft. Among these were the JN-4 "Jenny" airplane, the Martin B-2 bomber, numerous other bombers, balloons, airships, the C-130 and fighter planes, including the F-15.

Stationed at Langley is the prestigious 1st Fighter Wing (1FW), also referred to by some as America's "First Team." The 1FW has made a name for itself in national air power history. They have received multiple distinguished unit citations and Air Force outstanding unit awards. The wing was the parent unit of the first winner of the Medal of Honor for aerial combat.

A key player on America's "First Team" is the 1st Medical Group. The 1st Medical Group provides medical services for the 1FW during wartime and peacetime. They were responsible for setting up the first operational air transportable hospital in the Persian Gulf during Operation Desert Shield. In peacetime, the 1FW hospital serves a patient population exceeding 75,000. The hospital is a 70-bed, acute care facility providing both inpatient and outpatient medical and dental care as well as other medical services ranging from health promotion and food inspection programs to occupational physicals and health surveys.

Health care provided by the 1st Medical Group must meet TAC's high standards of quality, timeliness, continuous improvement, teamwork and sensitivity. To help meet these standards of excellence, the hospital is currently undergoing a $1.5 million renovation that will include a new obstetrics birthing center. Langley AFB and the 1st Medical Group have set standards throughout

Orthopedic technician Sgt. Drew Ford prepares a patient's leg for application of a cast.

Maj. (Dr.) Scott Cole, a pediatrician, is one of 45 physicians for the 1st Medical Group.

the command for the Total Quality Improvement (TQI) program. The hospital has set up ten quality improvement teams that are looking for ways to improve processes within the facility. A new suggestion program gives the workers a voice in improving how things are done. Also, the base and hospital now include TQI training as part of everyone's in-processing orientation.

Last year, the health care professionals at Langley provided 300,000 outpatient visits. Extensive services include aerospace medicine, dermatology, optometry, pediatrics, urology, family practice, ophthalmology, internal medicine, radiology and dentistry. During 1990-1991, the emergency services department was the fifth busiest of its kind in the Air Force. The dental clinic provided 321,000 appointments. The obstetrics unit ranked third with monthly delivery rates, averaging 106. These facts are astounding considering that the 1st Medical Group is only the 12th largest medical treatment facility in the Air Force.

If the hospital cannot meet the medical needs of a patient, two options are available. First, the patient may be evacuated to a military referral facility. The largest stateside naval hospital, the 1,000-bed Portsmouth Naval Hospital, is located 20 miles away. Aeromedical evacuation makes transportation to Malcolm Grow USAF Medical Center at Andrews AFB, Md., very convenient. Second, eligible patients may be referred to one of the many local civilian hospitals.

In fiscal 1993, Langley will implement a tri-service managed care program with Portsmouth Naval Hospital and McDonald Army Community Hospital at Fort Eustis. This will be the first tri-service coordinated care program within DOD. The initiative is designed to control health care costs within the Tidewater area while continuously improving health care services.

Conclusion

Langley AFB serves the military and civilian communities of Hampton Roads with distinction. The 1st Medical Group continually expands its services and keeps abreast of the latest developments in scientific research and technology to be ready for any contingency. For those who want to be on the "cutting edge" of modern health care services through continuous quality improvement, joining America's "First Team" could be the answer.

Capt. Deborah A. Seaman is the director of patient administration for the 1st Medical Group, Langley AFB, Va.

Managed Care Fellowships: Learning by Doing

Lt. Col. Paul W. Nice, MSC

This year several Medical Service Corps officers are participating in managed care fellowships under the Education with Industry (EWI) program. As DOD implements the Coordinated Care Program, the military services are expanding opportunities for their members to get the experience necessary to effectively compete for civilian health care resources in a managed care envrionment.

My EWI fellowship is with INOVA Health System in Northern Virginia. INOVA is a multi-hospital system that also includes urgent care centers, nursing homes, home health care. The company's three major themes go hand-in-hand with the objectives of the Air Force fellowship. INOVA wants to be an integrated health system, a total quality organization, and wants to be responsive to major customer groups including employers, insurers and managed care plans. Air Force medical facilities will likely buy care from large, integrated regional systems; the Medical Service is striving to become a total quality organization; and we need to fully understand the incentives of the various middlemen in the industry — Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Third-Party Administrators.

INOVA participates in several physician-hospital organizations (PHOs), and I work in the office that runs the two smaller PHOs. The smallest consists of the four INOVA hospitals and about 500 of their physicians who are interested in participating in managed care arrangements. They cover the area of Northern Virginia adjacent to Washington, D.C. The next largest group is a consortium of 13 hospitals and associated physicians who cover an expanded service area in greater Northern Virginia. INOVA also participates in a large regional network that appeals to benefit plans with "covered lives" in Virginia, Maryland and D.C.

Many fellowships rotate an officer through numerous functional areas for several weeks at a time. However, a strong focus on managed care argues for a more in-depth approach. Consequently, I am assigned to be a full-time shadow to INOVA's vice president, giving me the perfect vantage point to participate in network development, assessments of potential customers, contract negotiation and the analysis of operational contract terms and pricing mechanisms. I have become very aware that everyone in the chain between the patient and the ultimate payer — the hospitals, primary care physicians, specialists, health plans and employers — expects different attributes of a "good deal."

The most enjoyable part of my fellowship has been attending key management meetings with INOVA executives. Their extremely candid discussions of anti-trust issues, tax exempt status, physician relations and the penetration of aggressive managed care plans into the region have been fascinating. I learned much by observing their investment of time and training in a Total Quality Management (TQM) program. They are in their fourth year of implementation now and still have a long way to go. This pace is common to successful quality organizations; those trying to adopt the TQM culture too quickly are likely to fail.

I also had the unique opportunity to attend the Virginia General Assembly session in Richmond, Va., with INOVA's chief legislative liaison (lobbyist). We followed several bills through subcommittee hearings, committee approvals and consideration before the full legislature, but the real action was in the informal elevator and hallway caucuses. Almost every piece of legislation was a somewhat hasty compromise developed in the whirlwind of the short, intense session. It was clear that major changes would be difficult, if not impossible, to accomplish.

Going to a few conferences and reading the trade journals do not make anyone an expert in managed care. Even an intensive, 10-month fellowship really just makes us appreciate how much we do not know. Managing an employee health benefit differs significantly from managing a hospital. In the recent past, Air Force hospital administrators learned that they could earn more manpower and funds by increasing their workload. Now, under managed care, they will be working with a fixed, drawn-down budget at the local level and must learn to minimize use. This shift in thinking leaves us on unfamiliar ground. However, we do understand best the impact and complexity of readiness, retention and the special needs of military families. The services should control the delivery system, but they need the proper talent and expertise to do it. The EWI fellowship program helps develop that talent.

Lt. Col. Paul W. Nice is an Air Force senior health policy fellow at INOVA Health System in Springfield, Va.

From the Yellow Pages to Coordinated Care

Serving Patients Better

Col. John G. Wilson, MSC

With the growing demands for increased accessibility and the shrinking resources in Air Force medicine — less money, closing facilities — come concerns and frustrations from all segments of the beneficiary population. Those who manage health care at the local level spend a tremendous amount of time explaining the limitations placed on our delivery system, knowing that the Air Force medical team would like nothing better than to be able to meet the needs of every beneficiary seeking care in Air Force hospitals and clinics. Although today's disappointments and concerns are valid, Air Force medicine has come a long way in recent years and can be proud of its progress toward providing services at the level of demand.

The Way it Was

Only a few years ago, the Air Force had little to offer beneficiaries who required services beyond the capability of military facilities. These patients were disengaged to CHAMPUS or Medicare. Contracting rules and regulations did not allow Air Force physicians to make direct referrals or recommendations, and patients were forced to select a civilian specialist by contacting the County Medical Society, consulting the yellow pages or depending on the recommendation of a friend or neighbor. This system frustrated Air Force health care providers because they could not recommend a competent specialist to the patient, and the patients suffered when they did not select the best qualified civilian providers. Many times, the patient would choose a provider who did not accept CHAMPUS or Medicare assignment, creating billing problems and personal financial hardship when charges exceeded allowable fees. Needless to say, the lives of Air Force health benefits advisors were complicated by trying to help the patients and providers resolve these issues.

Often, without adequate funding to buy consultations, diagnostic procedures and other medical services through cooperative care and contract medical services programs, medical treatment facility (MTF) commanders were forced to disengage patients early to civilian providers. They had to do this even though the consultation or diagnostic test results would probably have shown that the patient's condition could have been treated easily in a military facility. Once released, the patients frequently remained in the care of the civilian providers for extended periods of time, adding significantly to escalating CHAMPUS costs. Many in health care management were frustrated by the inability to use taxpayer dollars more efficiently and by not being able to assist patients requiring health care services in the civilian community. After these frustrations attracted the attention of those in the Air Force surgeon general's office, many positive changes took place and opportunities increased to better serve the patients.

The Way it Changed

One of the first major initiatives by the Air Force Medical Service to improve service to beneficiaries was the establishment of the Health Care Finder program. This program allows local MTFs to make agreements with selected civilian providers in the community who will serve CHAMPUS and Medicare beneficiaries, and it allows military health care providers to recommend civilian providers to patients requiring services not available in the military facility. Participating civilian providers agree to accept reimbursement at or below CHAMPUS prevailing rates and to submit paperwork to the fiscal intermediary. Patients and military providers benefit from the Health

Care Finder program because Air Force physicians can now assist in referral, and patients do not need to worry about excessive paperwork or charges exceeding CHAMPUS rates.

To provide greater access for beneficiaries, additional initiatives were established at selected locations. For example, Primus clinics were opened in civilian communities. Also, the CHAMPUS Reform Initiative brought enormous medical resources to people seeking care in California and Hawaii.

The Partnership program augments Air Force hospital and clinic staffs with civilian health care resources funded through CHAMPUS. A patient who may have experienced difficulty obtaining an appointment with a military provider can now be given an appointment with a civilian provider treating patients in the military facility. The patient incurs no costs because the civilian provider is reimbursed 100 percent by CHAMPUS. The CHAMPUS deductible and co-payment are also waived. Sometimes a military physician is allowed to provide care in a civilian hospital when the military provider is available but limitations on facility space or other support services will not allow the care to be provided within the military facility. This saves the patient money that would be necessary if using a civilian physician under CHAMPUS.

Following the implementation of the Partnership program, Congress authorized the Alternate Use of CHAMPUS program, giving local MTF managers access to funds to provide patient care services and thereby reduce CHAMPUS expenditures. This program has brought previously unavailable services into military MTFs and provided expanded services to Air Force beneficiaries. Congressional action giving military hospitals access to funds for the initiation of programs to increase the efficiency of health care organizations resulted in the Management Efficiencies program. This program increases access for patients who could previously not be served because of limited MTF capabilities.

The Way it Will Be

Now the Air Force is faced with its greatest opportunity to make significant advances in serving a growing beneficiary population by integrating these earlier programs with the new Coordinated Care Program (CCP). The CCP will give MTF commanders control of funds previously held centrally for CHAMPUS reimbursement. Commanders will use these funds to provide services to beneficiaries. Through astute management of previously designated CHAMPUS funds and local operation/maintenance resources, commanders can provide or arrange more efficient, cost-effective health care for their catchment area.

Although the CCP has not been tested in the field, its basic principles have been tested in Catchment Area Management demonstration projects over the past two years. Hospital commanders of five DOD MTFs have been given direct control of CHAMPUS funds for their catchment areas. Two of the five demonstration projects are Air-Force-managed programs, called Catchment Area Management (CAM) demonstrations, in Austin, Texas, and Phoenix, Ariz. CHAMPUS funds are transferred directly to the local operating/maintenance accounts of the 67th Medical Group, Bergstrom AFB, Texas, and the 58th Medical Group, Luke AFB, Ariz. The experiences of these two Air Force demonstration sites clearly indicate the great potential of the CCP to increase patient services and control costs.

The objectives of the CAM demonstration are very simple: to contain CHAMPUS costs while enhancing quality of care, to increase patient access to care and to improve patient and staff satisfaction with the Air Force medical system. The goal of the CAM demonstration and coordinated care is to enroll eligible beneficiaries in a preferred provider network comprised of military health care providers and carefully selected civilian providers. The network of civilian providers includes those hospitals, physicians, laboratories and medical equipment companies who agree to serve Air Force beneficiaries at discounted rates and meet Air Force quality standards.

By joining the CAM program and agreeing to use only those providers who are part of the preferred provider network, members enjoy many benefits. They have the option to select a primary care provider in either the military facility or the civilian community near their home or workplace. Members electing a civilian provider call directly to that office to arrange appointments. Members' standard CHAMPUS deductible and CHAMPUS co-payment for office visits to the primary care provider are waived. Also, members receive priority for MTF appointments, they do not need to file CHAMPUS claim forms, they have access to a case management program with authority to arrange medical services not routinely authorized under CHAMPUS and they can call on a dedicated, member services staff for help with any problems or questions.

The Way it Is

Because the CAM demonstration provides the basis for the CCP, reviewing early indicators of its effectiveness can provide answers to important questions. At the Phoenix, Ariz., demonstration site, the first question answered was: "Will military health care beneficiaries relinquish their ability to get care from any physician of their liking and agree to use only civilian providers in the CAM network?" The answer to this question came

quickly as more than 13,000 CHAMPUS-eligible beneficiaries joined the program in Phoenix within the first two years.

The second question answered is a question that the CCP will face at each implementation site: "Will civilian providers take interest in joining a preferred provider network and in offering discounts on prevailing rates?" The answer in Phoenix was, "Yes." A civilian network consisting of 15 local hospitals, more than 500 health care providers and a wide range of other health care services joined the program and offered discounts of up to 40 percent off CHAMPUS prevailing rates.

The CAM demonstration at Phoenix was monitored for several months in its first full year, fiscal 1991, to determine whether it would meet the specified program objectives. A fiscal 1990 and 1991 workload comparison revealed that MTF outpatient visits, patient bed days, operations and births had increased. The number of non-availability statements issued decreased 16 percent. Overall, use of the military hospital increased while the number of outpatient visits paid for by CHAMPUS, CHAMPUS admissions and total bed days under CHAMPUS declined. The Air Force hospital's clinical laboratory procedures increased 12 percent and X-ray procedures increased by nearly 36 percent. Local management of CHAMPUS funds allowed the military to enhance MTF ancillary services, offering better services to network civilian providers and minimizing costs to beneficiaries.

Because patients are now referred only to civilian providers with proven track records who meet Air Force credentialing requirements, the CAM program has improved the quality of patient care in Phoenix. Patient surveys have been overwhelmingly positive, showing 97 percent of respondents satisfied with service under CAM. Satisfaction with the MTF is high because of the facility's ability to offer new services, and because military physicians play a more direct role in arranging referrals to quality civilian sources.

Results of the first full fiscal year of operation revealed that, for the first time in documented history, the dollar amount of bills paid for CHAMPUS claims in Phoenix was less than amounts paid the previous year. Of the $31 million approved by DOD and allocated to the demonstration in Phoenix, only $27 million was spent in direct support of the program. Air Force MTFs participating in the demonstration used the difference between the budgeted amount and actual expenditures to procure additional equipment, services and facilities that will enhance future health care services.

Conclusion

Every member of the Air Force Medical Service can be proud of the efforts made over the years to improve the quality and availability of medical care for dedicated Air Force members, retirees and their families. Opportunities to offer more support have never been greater than they are today, with an ever-increasing number of health care beneficiaries, and the Medical Service is rising to the occasion as it applies experience from the CAM demonstration to implementation of the new Coordinated Care Program.

Col. John G. Wilson is the commander of the 58th Medical Group, Luke AFB, Ariz.

Ms. Reva Lemley

Ms. Reva Lemley, winner of the 1991 Health Benefits Advisor (HBA) of the Year Award, never has a dull moment on the job. Keeping up with CHAMPUS benefits and helping more than 8,000 beneficiaries from Nebraska, Wyoming and Colorado understand those benefits are constant challenges. "My job is interesting, and I learn something different every day," said Lemley of her position at the 90th Medical Group, F.E. Warren AFB, Wyo. "It's rewarding to use my information and knowledge of the CHAMPUS program to help other people."

Lemley did not become an expert overnight. She has been working as an Air Force HBA for 13 years. When Lemley began her career with the Air Force at Whiteman AFB, Mo., the HBA position was just being introduced. "At that time," said Lemley, "I was just like everybody else. I knew I had CHAMPUS, but I didn't know anything about it." She learned through hard work and determination. "I was sent back into the surgery ward in an empty room with a regulation. Basically, I learned CHAMPUS by reading, asking a lot of questions and getting help from my NCO in charge at the time."

When Lemley first began working as an HBA, she dealt only with civilian referrals, the referrals that doctors write for active duty and retired members and their families to get civilian medical care when the military system does not have the capability to meet their particular needs. Eventually, she was given the supplemental cooperative care program to work with, which authorized funding for procedures, such as diagnostic procedures and evaluations, done through civilian medical care to help military doctors care for their patients. The Air Force health care program has changed even more since then.

"Soon we were given the Health Care Finder program," said Lemley, "which meant going out to civilian providers, asking them if they would be willing to accept assignment with CHAMPUS on a regular basis and sending them an agreement to sign." Without an agreement, providers can accept CHAMPUS assignment on a case-by-case basis, but an agreement helps "lock them in." As Lemley pointed out, "They can cancel an agreement at any time. It is not a contract." Lemley has not had to go out and get all 80 Health Care Finder providers on her own. "Often, the doctors' offices contact me, especially if they are retired military, or have been in the miltary, and are now in private practice," said Lemley.

Under the Partnership program, civilian health care providers come into the military system and treat CHAMPUS-eligible patients. "We can bring in additional specialties and capabilities to our medical facility at no cost to the patient," said Lemley. "We also reduce CHAMPUS dollars because the civilian providers accept a certain percentage rate of the CHAMPUS allowable." Patients appreciate the advantages of increased capabilities. For example, an allergy partner comes to the 90th Medical Group at least two times a month. "It seems like once we get a new capability, people just come out of the woodwork. They have been putting off going to see a civilian doctor because they couldn't afford it," said Lemley.

Keeping up with automation has been a key factor in Lemley's success as an efficient HBA. She stores lists of partners and health care finders and her information logs in a computer. "I use this to do my reports, and if the commander or hospital administrator needs to know how many CAT scans we've done, all I have to do is go to the computer to bring up the information," said Lemley. She also has a program that prints information onto frequently used forms, and she uses the computer to print out personalized Health Care Finder agreements. "We are now a demonstration base for the new CD-ROM format, which will make all of our policy manuals and regulations available to us on the computer via the CD-ROM disk," said Lemley.

Lemley takes her job seriously, fulfilling her role in the Air Force Medical Service mission. "I have to ensure that our patients get the best care available and that the CHAMPUS program is used to the fullest extent. I ensure that patients understand the program as much as possible through briefings, commander's calls, newcomer's orientations and beneficiary workshops," said Lemley. Her favorite part of the job is contact with the patients. "I enjoy working with the beneficiaries and having the satisfaction of helping somebody. The 'thank-yous' are really wonderful to hear."

Obtaining Partnership Agreements

Learn the Keys to Successful Negotiating

Lt. Col. Richard E. Schroeder, MSC

"Congratulations, Capt. Anderson, you are the new director of managed care," said Col. Randolph Huxley, the hospital administrator. "Of course, this will be in addition to your position as assistant administrator for patient affairs, but we know you can handle the challenge."

"I can?" Capt. Anderson replied hesitantly. "But what will my responsibilities be?"

"First, you will have to organize your office and write operating instructions. Then you will have to save the Air Force money."

"How can I do that?" asked Capt. Anderson.

"By negotiating discounts with physicians, hospitals and ambulatory surgery centers that are currently paid by CHAMPUS," Col. Huxley replied emphatically.

"But I've never negotiated anything before," Capt. Anderson protested.

"You can do it," the colonel continued. "I have great confidence in you."

"And what about new staff to help me?" pleaded Capt. Anderson.

"We will work that out later," Col. Huxley said in a firm voice.

Feeling intimidated and confused, Capt. Anderson left the room. While walking away, she asked herself, "How can I learn this new skill? Who will help me?"

Walking in a trance, she bumped into Lt. Col. Kits Singer, the associate administrator. "What has you so down?" Lt. Col. Singer asked.

"I've just been appointed the new director of managed care. That means I have to learn how to negotiate. Can you help me?" she pleaded.

"I've been to a negotiating course," replied Lt. Col. Singer. "Come into my office and I'll try."

Lt. Col. Singer settled back into his chair and asked, "Have you ever bought a house or car?"

"Yes, I have."

"What was the first thing you did?"

"I priced houses in the paper, read realty reports, talked to my sponsor and decided that I wanted three bedrooms."

"All before you even looked at a house?" asked Lt. Col. Singer.

"Yes, I needed to know what I was looking for so I could find a house that would meet my needs."

"Great!" said Lt. Col. Singer. "You already know how to start negotiations. In Stage One of negotiations, interests must be determined. You did this when buying your house by gathering data on the market and establishing criteria. In short, you determined what your interests were. This is called interest bargaining. What did you do next?"

"I asked my husband what he wanted in a home."

"Super, super!" exclaimed Lt. Col. Singer. "In Stage One, you also need to find out the interests of the other parties involved (1). In our case here at the hospital that would be the medical staff, the patients, the surgeon general and DOD. And what did you do after discussing your husband's criteria?"

"We decided how much we were willing to pay," Capt. Anderson answered.

"Exactly, and in the medical arena, you must do the same. You need to study the market. If you want to know about physicians in your area, you can do research by reading books such as the *Directory of Physicians in the United States* or the *Directory of Medical Specialists* (2, 3). If you want to know about institutions, you could

use the *Directory of Investor Hospitals* or the *AHA Guide to the Health Care Field* (4, 5).

"You might also want to ask other medical treatment facilities what they are paying for partner care," he continued, "and check current CHAMPUS reimbursement rates as well as read the current literature on managed care contracting."

"After that, are we ready for Stage Two?" Capt. Anderson asked eagerly.

"No, No!" Lt. Col. Singer said quickly. "We cannot be ready for Stage Two when we haven't determined the interests of the people we are negotiating with, our opposition."

"Money," said Capt. Anderson, "just like when buying a house."

"Right," responded Lt. Col. Singer, "and when talking about money, you need your negotiating skills. Your job is to obtain appropriate, high-quality medical services at the lowest cost. You can do this by negotiating a low price.

"For example, if you learn that fixed costs of a clinician's practice range from 40 to 60 percent of total costs, then if we provide the facility, staff, equipment and supplies, we should deduct those expenses from any negotiated fee."

"But won't the physicians be insulted if we only offer 50 percent?" Capt. Anderson asked, somewhat perplexed.

"Now you sound like a real estate agent trying to entice someone to offer more than the house is worth. The agent's saying that the seller would be insulted is one of the oldest tactics in the book. Remember, the agent works on a commission, so the more a buyer pays, the more the agent earns.

"Tactics, tactics, tactics. They are a vital part of negotiations. We will talk about that more, but first let's finish Stage One."

Capt. Anderson thought they would never leave Stage One.

"If the interest of your opponent is money, how can you control that?" Lt. Col. Singer asked.

Capt. Anderson thought for a moment before she answered, "I know — through a fixed price or capitated bid. This requires the physician or hospital to provide a single price for all the medical services they provide.

"I could also implement a strong utilization review program. This could be done three different ways: by monitoring partners' charges to see if they are accurate, by comparing the codes of partners' patient visits to standard codes for their specialty or by having our own medical staff review their records to make sure that we are not being charged for services not required or not given."

"We must be sure," she added, "that prices charged are the prices agreed to, and that the providers do not see patients just to increase their revenues."

"And how would you do that?" asked Lt. Col. Singer, interested to hear her answer.

"By auditing the bills, medical records and the codes the providers assign to the outpatient visits or inpatient stays. This way we could see if they are overcharging, charging for services not rendered or assigning improper codes for billing."

"Wonderful," responded the lieutenant colonel. "You have now determined your interests and your opponents' interests and figured out a method to control expenditures. Now you need to develop a strategy for win-win negotiations."

"Win-win?" asked the captain. "I want to win — let them lose."

Lt. Col. Singer interrupted, "To establish a long-term relationship, both parties must receive some benefit. Remember, we want quality care and access for our patients, and if we win

and the provider loses our patients will suffer.

"What was your next step when you purchased your home?" continued Lt. Col. Singer.

"My husband and I agreed on what we would say to the real estate agent."

"In other words, you organized your negotiating team. In your case, it was you and your spouse. In our case, it will be you, a physician advisor who has knowledge of that specialty and someone like me."

Feeling embarrassed, Capt. Anderson asked, "You?"

Lt. Col. Singer laughed and said, "In negotiating, it is called the higher authority. People in car sales use higher authority all of the time. Have you ever heard them say that they have to talk to the manager? Well, they hardly ever actually discuss your deal with the manager. But this gives them someone who has power over the negotiations and someone whom you cannot talk to. Also, if they make a mistake in the heat of the battle, the higher authority can overrule them. The hospital commander and I are your higher authority. Now, we are discussing tactics."

"Tell me more," urged Capt. Anderson. "This sounds like fun."

"There are hundreds of tactics and strategies (6). Let me tell you about a few. First, you must assess what power you have in the negotiations (7).

"There are six sources of power: position, coercive, reward, personality, information and bureaucratic. Let me show you a chart that I have developed to explain each." Lt. Col. Singer pulled an index card out of his desk and handed it to Capt. Anderson.

"I think I understand most of these," said Capt. Anderson, "but how could I use them in negotiations?"

"If a partner wants you to allow referrals to their private practice, all you have to say is that DOD does not allow it. The individual to whom you tell this cannot argue with DOD. Who can they call? You can use your position, promises of reward, your own personal strengths and the information about competitors or existing policies and procedures you have gained through research to obtain an agreement that is most favorable to the taxpayer and the patient," Lt. Col. Singer explained.

"Wow!" exclaimed Capt. Anderson. "Most of these are already available to me."

"Absolutely," answered Lt. Col. Singer, "all except the information. To get that you must do your homework, as we discussed earlier, before you start negotiating an agreement."

"What is the next tactic?" asked Capt. Anderson.

"You must establish ranges for settlements."

"How do I do that?"

"This is a dollar figure based on your research and what is acceptable to DOD. For example, your negotiating team may determine that you are willing to pay between 40 and 60 percent of allowable CHAMPUS charges. Those would be your ranges.

"Third, you should develop arguments and counter-arguments, and fourth, you have to develop the right attitude," answered Lt. Col. Singer.

"Attitude?"

"Yes, negotiating is won on attitude. You must think that everything is negotiable. For example, expect the providers to have their own staff to handle billing, make appointments and provide nursing support. The providers might be planning to supply the services of their staff, but if you do not ask, you will not get them.

"You should be polite, calm, positive and never hurried. Never, never, negotiate when time is on the other party's side. You will tend to make mistakes."

"Can we move to Stage Two now?" Capt. Anderson asked.

"Well, actually we have," said Lt. Col. Singer. "In Stage One we determined interests by gathering background data and establishing criteria; we set dollar limits, organized a negotiating team and set some controls.

"Once all that is done, you have to start negotiating. The actual negotiations are Stage Two. This is when you use all the tactics we discussed."

"And is there a Stage Three?"

"Yes. It is called closure. During closure, you should settle on the items you agree upon, write them down and then discuss the areas of disagreement. Never work details out later."

"What do you mean?"

"Whenever you try to put anything off, conversations are forgotten or a new priority comes up. Putting an item off is a common tactic used to avoid doing something that a person does not plan to do."

"Oh, I see, such as getting extra staff to support this managed care project?"

"What do you mean?"

"Well, earlier, when I met with Col. Huxley, I requested extra help, and he said that we would work it out later."

Lt. Col. Singer smiled to himself. He knew that the great majority of health care administrators like Col. Huxley were well-trained in negotiating skills, and he knew that the civilian providers Capt. Anderson would meet would be even more experienced. He also knew that Capt. Anderson would realize their skills when she encountered the tactics he had discussed with her earlier. Recognizing tactics of the opponent is a skill that comes with practice, and Capt. Anderson had recognized one tactic already.

"Anything else?" Capt. Anderson asked.

"Yes," Lt. Col. Singer said, "two more items. There are dozens of books in the library on negotiations. Read a few. We only touched on some of the hundreds of tactics that exist. Finally, always congratulate your opponent."

Capt. Anderson thought back to Col. Huxley's remarks, "Congratulations, you're the new director of managed care." She felt good. She had already learned her second tactic.

"Congratulations," said Lt. Col. Singer as he stood up.

"Congratulations for what?" Capt. Anderson asked.

"You've just learned the three stages of negotiations as well as a few tactics."

"You're right," Capt. Anderson replied. "Sometimes you can just keep talking until the other party agrees. Another tactic, I suppose?"

Lt. Col. Singer did not reply. He knew that Capt. Anderson was well on her way to being an expert negotiator.

Lt. Col. Richard E. Schroeder is an assistant professor in health care administration for the Army-Baylor program, Academy of Health Sciences, Fort Sam Houston, Texas.

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Special Note: World War II Air Force Medical History Available in Reprint

The Air Force Medical Service has a long and proud tradition of support to American aviators. Although the Medical Service was formally a part of the U.S. Army Medical Service until July 1949, its origins can be traced to the creation of a separate Air Surgeon for the Army Air Forces in early 1942. Medical support for the Air Forces expanded enormously during World War II. As part of the Air Force commemoration of World War II, the Medical Service has reprinted the history, *Medical Support of the Army Air Forces in World War II,* by Mae Mills Link and Hubert A. Coleman.

Copies of the paperback are available at no cost to official addressees and at a nominal fee to unofficial addressees. Orders may be telephoned to (202)767-0412 (DSN: 297-0412) or mailed to CAFH/HSR, Bldg. 5681, Bolling AFB, D.C. 20332-6188.

The Little Things Mean A Lot

SSgt. Michael A. Dols

For many of us, death and tragedy happen to "the other guy." Unfortunately, this is not always the case. Last year, whether by pure chance or terrible misjudgment we do not know, an entire town and many individuals from outside the community were bound together by a local fire. Many lives were changed. I know I was changed, and I think for the better.

While working in the inpatient unit of a military hospital in the states, I had become a bit jaded toward the seemingly minor problems of the patients I dealt with. It was hard to feel that I was doing anything important when the most serious case I took care of was a patient with lower back pain. I was used to working in the emergency room where anything and everything came through the door. True, I enjoyed my new responsibilities as NCO in charge of the inpatient unit, but I was beginning to question my need to be there. For the most part, the patients were usually self-sufficient. They did not need much help from the staff, and when they did, it was becoming more and more of a nuisance to me. On September 15, 1991, however, my attitude was changed in a way I never expected.

I had come to work expecting just another day like any other, but before I had even gotten through the door, I was being paged to report to the emergency room. When I reached the emergency room, the first thing that hit me was the stench; there is no mistaking the acrid smell of burnt flesh and hair. I was given a quick run-down on the fire that had taken place. The situation was tragic. An oil tank had been hit by lightning and had burst into flames. During the fight with the fire, the fire truck was suddenly engulfed in flames, killing one volunteer fire department member and seriously injuring seven others. Two of the victims had been sent to our hospital because one was active duty Navy and the other had recently left the Navy. I was asked to stay and help.

When I entered the trauma room, I was welcomed by a most unpleasant sight. The victims, I'll call them Joe and Bob, occupied each of the two beds. Both of the men were breathing through tubes down their throats. Joe was covered in bandages, plastic and blankets to keep him clean and warm, and a technician was standing at his head with an Ambu bag, forcing oxygen into his lungs. Bob was breathing on his own, but he also was covered from head to toe. Both men had six IVs running into their arms and legs. I and three others spent the next 14 hours dressing and redressing burns, monitoring heart and respiratory rates, monitoring the respirators, changing IV bags and doing any number of other tasks. By the end of the day, both men were unresponsive and on respirators.

About 10 a.m. the next day, the family started to arrive. Joe and Bob are brothers, and the family came from all over the state to see them. By the time the family arrived, most of the major procedures were finished, and we were doing routine things to keep the victims comfortable until the plane arrived to take them to the burn center for further treatment. It was during this time that I discovered what I had forgotten.

The family did not seem to notice that their sons were on state-of-the-art respirators or that the hospital was equipped with the latest in medical technology. They noticed us, the staff, and the things we were doing: wiping Joe's eyes when they were tearing, putting Bob's arm back up on the bed for him because he could not move it, covering them both before someone came into the room. Of all the things we did for their sons, the family thanked us most for remembering that they were men and for helping them keep whatever dignity we could during the whole ordeal.

When Joe and Bob were on their way to the burn center, I started thinking about the tough times they and their family had ahead and about how Joe and Bob would have to fight to survive for the next six months. It felt good to know that I had helped them survive, not just because I kept them breathing or because I did not let their IVs run out, but because I let them know that someone cared. They knew that someone was there to help them and to take care of the little things that they could not.

Back at work on Monday, as I was helping a patient get dressed, I thought about how hard it would be to get dressed with a sore back. Later, I thought about how hard it would be to eat with a broken right arm. Then I realized how many people I had helped just by doing the little things for them. Even the most insignificant act really is important.

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Welcome to Patrick's Satellite Pharmacy. May I have your control number and ID please?

In early 1989, Patrick AFB, Fla., opened the first DOD satellite pharmacy with drive-through windows for customer convenience. Patients call in their refills 24 hours a day on any one of eight telephone lines dedicated to an automated prescription refill answering system, the Dytel system. Each refill is given a control number that indicates the day the order will be ready. To pick up their refills, customers simply drive up to the window, give a prescription control number, show their military identification card, receive their medication and drive off, never leaving the car or looking for a parking space. The Patrick Satellite Pharmacy handles 800 - 1,800 prescription refills daily, eliminating long waiting times at the main pharmacy.

(Top) Red Cross volunteer Mr. Mike Novak distributes refills at the pharmacy's drive-through window. (Left) SrA. Tammy Brewer restocks the satellite pharmacy shelves. (Above) 1st Lt. Patrick Casey checks the status of the Dytel automated refill phone-in system.